UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

LAMISIL (terbinafine HCl)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext. and options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES

CRITERIA:

- Documented diagnosis of onychomycosis.
- Authorized for 16 weeks per calendar year.

RE-AUTHORIZATION:

Same process as initial PA.

2/2/07